Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C.

In the matter of:	)	(
	)	(Docket No. 02-60
Rural Health Care Support Mechanism	)	(
	)	(

PETITION FOR RECONSIDERATION OF THE SECOND REPORT AND ORDER, ORDER ON RECONSIDERATION, AND FURTHER NOTICE OF PROPOSED RULEMAKING

I. INTRODUCTION

Pursuant to Sections 1.49, 1.51, and 1.52, as well as 1.06(a)(1) and (f) of the Federal Communications Commission (FCC or Commission) Rules of Practice and Procedure, 47 C.F.R. §§1.49, 1.51, 1.52 and 106(a)(1) and (f), the American Telemedicine Association respectfully submits this Petition for Reconsideration (Petition)) on behalf of ATA member institutions and individuals representing rural telemedicine/telehealth programs and recipients of the Rural Health Care Division of the Universal Services Fund Administration's rebates for telecommunications charges. The American Telemedicine Association (ATA) respectfully requests that the Commission reconsider the Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, with specific regards to the definition of rural and to provide other options for retaining currently eligible rural

communities for Universal Services subsidies, who are now ineligible due to the new definition.

II. SUMMARY OF ATA'S POSITION

1. The American Telemedicine Association and its represented membership and constituency supports the changes made in the Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking (*Second Report and Order*). We believe that the Commission has improved significantly the ability of rural health care providers to respond to the medical needs of communities; the ability to strengthen telemedicine and telehealth networks across the United States; to improve the availability and quality of health care services in rural areas; and to respond to widespread intrinsic and intentional outbreaks of disease. We applaud the Commission for the work done to improve the definition of rural to meet these important health care objectives and initiatives. We believe that the changes made to the definition or rural significantly improved the eligibility of many counties to participate in the Universal Services Rural Health Care Division (RHCD) subsidies.

2. The American Telemedicine Association has determined that a significant number of rural communities are now considered ineligible for Universal

Services RHCD after an application of the new guidelines. We would respectfully propose through this Petition to Reconsider that the Commission review the eligibility criteria in light of the communities who are substantially rural and adopt a policy to include the currently eligible sites.

3. The American Telemedicine Association proposal would not change the definition of rural but only grandfather eligible sites as of the date of the Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking (*Second Report and Order*), December 15, 2004. Sites would be grandfathered for an indefinite period, similar to the grandfathering of Federally funded telemedicine sites in the stipulations of the Safety Net Amendment.

III. BACKGROUND

4. Prior to the issue of the Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking (*Second Report and Order*), dated December 15, 2004, the determination of rurality was considered to be areas not located in a county within a Metropolitan Statistical Area (MSA) as defined by the Office of Management and Budget (OMB) or specifically identified as "rural" in the Goldsmith Modification to the 1990 Census data. At that time, 735 counties across the nation were considered to be ineligible for subsidies from the RHCD Universal Services program. What was not known about the ineligible counties was whether or not there were hospitals or other health care facilities

located in the geographic area (county). One hundred six counties were partially eligible under the pre-December 15, 2004, definition of rural. Statistics are from the staff of the Universal Services Administrative Corporation.

5. Under the new definition of rural, there are now only 159 ineligible counties and the number of partially eligible counties has increased to 855. Again, what is unknown is the impact that the increase in decrease in ineligible counties and the increase in partially eligible counties will have in relation to the presence of hospitals or other health care facilities in the newly eligible counties. The net benefit may be zero, as the link and analysis between newly eligible counties and the location of health care facilities has not been correlated.

6. The American Telemedicine Association and its constituency understand that the new definition of rural is determined by applying the following algorithm:

a. If an area is outside of a Core Based Statistical Area (CBSA), it is rural and no further determination needs to occur.
b. If an area is within the CBSA, it can be either rural or non-rural, depending on the characteristics of the CBSA:
    1. If a CBSA does not contain an urban area with a population of 25,000 or more, the site is rural and no further analysis is needed.

2. If a CBSA contains an urban area with a population of 25,000 or more, census tracts are the determination of rural or non-rural status:

    a) If a census tract does not contain any part of a place or urban area with a population greater than 25,000, then the census tract is rural and no further analysis is needed.

    b) If the census tract contains any part of a place or urban area with a population greater than 25,000, then the census tract is not rural.

Within the application of this definition and algorithm for rurality determination, we find that many areas previously considered not rural are now eligible. But, unfortunately, there are other areas that are a significant distance from the nearest tertiary care hospital or health care facility, with populations significantly lower than 25,000, that are now not considered rural. These very rural communities may have a critical access hospital, a community based hospital, or a federally qualified health center or rural health clinic.

7. The American Telemedicine Association presents the following examples:

Nebraska

a. In Nebraska, a statewide network has been developed to deliver health care services via telehealth and mental education to approximately 88 hospitals and clinics. The development of the Nebraska Statewide Network has been supported with and exists solely because of a partnership between federal, state and private funding sources. The purpose of the network is to

   1) Increase the quality, availability, and accessibility of health care
   2) Bring together hospitals within the state into a single, connected system that can provide patient clinical consultation, give providers continuing education and professional development and advance and provide for administrative connections

c. The Nebraska Statewide Network is very concerned that the new ruling with the new definition of rural will negatively affect the delivery of health care services within our state. Because the new definition changes the population stipulation from 50,000 to 25,000 for community eligibility, four hospitals that are serving as hub sites for our newly formed statewide network will no longer be eligible for funding through RHCD/USF. The hubs are the locations of the specialty services, the experts in clinical specialties, and the distance education providers. These hubs make connections to the network in order to provide services to the 80

plus rural locations on the network. Specifically, hospitals in the communities of Kearney, Fremont, Grand Island and Norfolk would no longer quality; all of these currently functioning hubs for the statewide network range between 26,000 and 42,000. These sites are critical to the success of the investment that the state and the federal government have already made in developing and sustaining the Nebraska Statewide Network.

b. Under the new definition, only one site, the community of Blair, would be added as an eligible rural site. This small gain in the new list of eligible sites does not offset the loss of the critical location of services needed by Blair.

Montana

a. Montana has five Telehealth networks that interconnect for the purposes delivering health care services to rural and frontier areas. telehealth providers and organizations in Montana are concerned that the new ruling and definition will have a negative impact on our most rural and sparsely populated states.

b. For example, under the previous definition, Montana communities under 50,000 were eligible for discounts. Under the new definition, these communities will no longer be eligible for support. In selecting a population threshold of 25,000, the Commission stated that they believed that urban areas above 25,000 possess a critical

mass of population and facilities. In Montana, that is not our experience. Our communities of Bozeman (pop 27,509), Butte (pop 34,606), and Helena (pop. 26,780), have limited medical specialty services and their residents must travel great distance to access medical care. If a person resides in Butte, Montana, and needs cardiology services, the closest tertiary care center would be in Missoula, Montana, 126 miles away.

c. Unmet health care needs of the population of Butte are met by providing services to them via telehealth. To provide the necessary specialty services to the citizens of Butte, Montana, a telehealth network connects those citizens with specialists in Missoula or Billings, MT. The average cost of a T-1 from Butte to Missoula is over $800 and from Butte to Billings is over $1200.00. The costs far exceed a comparable service in an urban environment.

d. The original intent of the universal service program was to assist rural healthcare providers and patients in accessing needed healthcare through cost effective telecommunication services. The method by which access was accomplished was by providing a network funded by the RHCD/USF, which reduced distance sensitive charges. Clearly the new definition of rural has had a negative impact on state like Montana, who is sparsely populated and has great distances between communities.

Virginia

a. The impact of the new rule defining eligible rural areas in Virginia has resulted in some unexpected consequences, despite a clear-cut increase in *potentially* eligible sites. A case in point is a small community hospital in Tazewell, Virginia, equipped with telehealth technologies funded through the HRSA Office for the Advancement of telehealth. This hospital is now considered to be located in an urban area based on the new order. Tazewell, Virginia, by the previous definition, was considered to be located in a non-metropolitan statistical area, and eligible for support through the rural healthcare support mechanism. Tazewell Community Hospital is a 56-bed acute care facility located in an Appalachian region of Virginia. The hospital utlilizes its telemedicine program for clinical consultations, ongoing patient care, teleradiology services, and for health professional education as mandated for relicensure by the Virginia State Board of Medicine. The cost of undiscounted broadband connectivity to support the telehealth program at Tazewell Community hospital is $880/month; with rural healthcare discounts that expense has been reduced to $320/month.
b. Tazewell County is reported by the Census Bureau to have a population of 44,449 citizens, with a size of 520 square miles and a total county population density of 85.4 persons per square mile.

With the 2000 census, the entire county has now been designated a "micropolitan area". Tazewell town, population 4100, is considered urban because it is located in Tract 9911.00, non-rural because it is in the Bluefield, VA-WV CBSA and 2) it contains part of the Bluefield urban cluster (UC). The following is language from the Census Bureau which "delineates UA and UC boundaries to encompass densely settled territory, which consists of core census block groups or blocks that have a population density of at least 1000 people per square mile, and surrounding census blocks that have an overall density of 500 people per square mile". In attempting to understand the designation of that tract as part of the Bluefield urban cluster, we note that tract 9911.00 is neither contiguous with Bluefield WV nor Bluefield, VA. We believe that the tract is classified as part of the Bluefield urban cluster because of its localized population density. In the case of tract 9910, despite the town size of 4,100, and most of surrounding census tracts identified as rural (including on the USAC web page), the density of the census tract in which the hospital is located is 676 persons/sq mile (>500 persons/sq mile). We believe that it is this demographic that precludes eligibility for rural healthcare support - that is, because of the population density of the tract, and its

identification as being a part of the Bluefield urban cluster despite its considerable distance from Bluefield.

c. There is no hospital in Bluefield, Virginia (population 4,996). The trip from Tazewell Community Hospital (141 Ben Bolt Avenue Tazewell, VA 24651) to the Bluefield Regional Medical Center (500 Cherry St. Bluefield, WV 24701) in Bluefield, West Virginia (population 11,124) is a 19-mile drive through mountainous terrain. The roads in Tazewell County consist of primary and secondary roads, and there is no interstate highway that passes through the county.

e. Much like Tazewell Community Hospital, rural hospitals tend to be located in the most populous census blocks of any region. Such hospitals cannot reasonably provide the health care services offered in a traditionally urban area. These hospitals have embraced telehealth technologies to improve access to services, however, such facilities ultimately will not likely be able sustain a telehealth program in the face of expensive broadband connectivity..

IV. ARGUMENT

1. Clearly, the increase in eligible and partially eligible counties is a desired effect of the new definition of rural. What is unknown at this time is the net

benefit of the inclusion of those counties as eligible for subsidies from the RHCD/USF. There is no data available as to how many of those now-eligible counties have hospitals or other health care providers. In addition, it is not know how many of the newly eligible health care facilities could be connected to a larger network of telehealth providers.

2. What is known is that with the reduction in the population requirement for urban designation from 50,000 people to 25,000 people, the nation will lose currently eligible sites. The loss of existing health care facilities supported by RHCD/USF subsidies for broadband access, that prior to the subsidies, were unaffordable, will result in the loss of health care services to populations that have unmet health care needs, that are remote and rural to the location of those services, and are most disparate.

3. The American Telemedicine Association recognizes that the intent of the new definition of urban was to improve access to RHCD/USF subsidies so that the nation and its rural health care providers would have improved access to broadband telecommunications. What is needed is a fix to the current limitations that does not exclude existing health care organizations. Any new recommendation that puts existing services out of business detracts from the overall goal of improvement.

V. RECOMMENDATIONS

1. The American Telemedicine Association respectfully requests that the Commission consider universally grandfathering all currently eligible rural sites with no end-date. Medicare has a precedent in place for a non-limited grandfathering of existing telemedicine sites in its guidelines for reimbursement (with regards to eligibility for payment for geographic areas) published in the Federal Register (Nov1, 2001, Volume 66, Number 212) which state:

"A federally funded telehealth program in existence as of December 31, 2000 regardless of geographic location."

The American Telemedicine Association submits this Petition for Reconsideration of the Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking (*Second Report and Order*).

Respectfully submitted,

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FOR:

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